HealthQuest - Confidential Questionnaire - Female

In order for us to provide you with quality health care, please provide us with the following information regarding your present state of health and medical history. Please note that all of this information is required by us to make an accurate assessment of your individual needs and to help you achieve the best possible results and is **completely confidential**.

Name		Date
Address		
Home Ph	Work	Mobile
Email address		
Date of Birth	Age	Blood type
Have you previously received Acupuncture / Chinese Medicine / Alternative / Complimentary / Naturopathic Care?		
How did you hear about our clinic? ☐Friend ☐Family ☐Yellow pages ☐Dr Referral ☐Internet ☐Other		

What are the main reasons that you have sought help for: (Select as many as you wish)

☐ **Treatment of a Specific Health Concern as described in the Main Complaints section below**

☐ Weight Loss ☐ Disease Prevention ☐ Pre-conception care ☐ Cardiovascular protection

☐ Diet ☐ Low Energy ☐ Immune system ☐ Sports performance

Goals and Expectations

What do you hope to get from today's consultation? _____

Rate the following questions from 1 to 10 … **1** = **very poor** and **10** = **excellent**

1. How do you rate your present level of health? ☐

2. How do you rate your present level of energy or vitality? ☐

3. How committed are you to improving your health? ☐

4. How confident are you in making suggested dietary, lifestyle and exercise modifications to improve your health and wellbeing? ☐

Are you willing to make changes to your diet and lifestyle to improve your health?
☐Yes ☐No ☐Maybe

Are you willing to increase your aerobic capacity with an exercise program?
☐Yes ☐No ☐Maybe

Are you willing to increase your strength and stamina with a strength resistance training program?
☐Yes ☐No ☐Maybe

How long do you feel it would take you to achieve your health and lifestyle goals?
☐ Days ☐Weeks ☐Months ☐Years

What do you think could stop you from achieving your health goals?
☐Time ☐Interest ☐Support ☐Money ☐Commitment ☐Health ☐Other

Main Complaint

Please describe your main health complaint
When did the condition develop
Do any activities or food make the condition worse?
Blood tests or other tests performed
Current treatment (if any)
Is the condition worsening / improving?

Other Complaints

Please list any other health concerns that you would like to improve

Past History

Please list any surgeries, fractures, accidents
List any serious illnesses that you have experienced
Number or frequency of colds and flu per year
Date of last physical examination by a doctor
Date of last blood tests
Other Tests performed – such as endoscopy, cardiograms etc.

HealthQuest - *FEMALE Symptom Analysis*

First Name: _____ Last Name: _____ Date: _____

Scoring ..... Circle the score in the column that best suits your symptoms, in either Severity or Frequency.

Severity Frequency
Column **A** = Never
Column **B** = Mild ——— **or** - Infrequent Symptoms (twice per week or less)
Column **C** = Moderate — **or -** Frequent Symptoms (3 to 6 times a weekly)
Column **D** = Severe —— **or** - Daily Symptoms

Note: *Circle the zeros if there is no symptom as well as numbers when there is a symptom*

Section 1.	**A**	**B**	**C**	**D**
1. Curved spine, height loss, stooped base of neck hump (dowager's hump)	0	2	5	10
2. Bone pain, back, hip or knee pain	0	2	5	10
3. Spinal problems, pain, Sciatic pain	0	2	5	10
4. Osteoporosis	0	2	5	10
5. Recent broken bones, fractures	0	2	5	10
6. Arthritis - Osteo/Rheumatoid	0	2	5	10
7. Joints swelling painful, deformity, injury, stiffness	0	2	5	10
8. Noisy joints (creak, grind etc.)	0	1	3	5
9. Nodules on fingers	0	2	5	10
10. High uric acid level	0	2	5	10
11. Damaged disc, slipped disc	0	2	5	10
12. Bursitis or tendonitis	0	1	3	5

1. Total .....

Section 2.				
1. Tightness or pain in back, neck or shoulder muscles	0	2	5	10
2. Muscular spasms, cramping	0	2	5	10
4. Stiffness in muscles	0	2	5	10
5. Tenderness, pain in muscles	0	2	5	10
6. Weakness in muscles	0	2	5	10
7. Trembling (fasciculation)	0	2	5	10

2. Total .....

Section 3.				
2. Chest tightness on stress or exertion	0	2	5	10
3. Palpitations, arrythmias, extra beats	0	2	5	10
4. Swelling of the ankles	0	2	5	7
5. Shortness of breath on exertion/rest	0	1	3	5
6. Calf pain on exercise	0	2	5	7
7. Dizziness on exertion	0	2	5	7
8. Previous angina attacks, heart attack or stroke	**No**		**Yes**	(10)

Section 3 continued ...	**A**	**B**	**C**	**D**
9. Known cardiac murmur or condition	**No**		**Yes**	(10)
10. High blood cholesterol, triglycerides or blood clotting problems	**No**		**Yes**	(10)
11. Blood Pressure or Heart medication	**No**		**Yes**	(15)

3. Total .....

Section 4.				
1. Blue, numb, cold fingers or toes	**No**		**Yes**	(10)
2. Ulcers, sores on legs and feet	**No**		**Yes**	(10)
3. Shiny, discoloured, hairless skin on arms or legs / Varicose veins	**No**		**Yes**	(10)
4. Cramps, pain in legs when walking	0	2	5	10
6. Pins and needles, numbness - hands, feet	0	1	3	5
7. Fluid retention feet, legs, body	0	2	5	10
8. Difficulty with written or spoken words or concentration	0	1	3	5
9. Dizzyness, ringing in the ears	0	1	3	5
10. Fleeting nausea / Hearing loss	0	1	3	5
11. Previous deep vein thrombosis	0	2	5	10
12. Take Anti-clotting medication	**No**		**Yes**	(18)

4. Total .....

Section 5.				
1. Morning headaches	0	1	2	3
2. Feel tired, nervy, weak	0	1	2	3
3. Ringing in ears / Sleepy, dizzy	0	1	2	3
4. Hi Blood Pressure / Heart medication	**No**		**Yes**	(15)
5. Flushing with no known cause	0	1	2	3
6. Tingling and numb hands and feet	0	1	2	3
7. Blurry vision	0	1	2	3

5. Total .....

Section 6.	**A**	**B**	**C**	**D**
1. Smoker	**No**		**Yes**	(10)
2. Cough	0	2	5	10
3. Asthma, Wheezing	0	2	5	10
4. Repeated chest infections	0	2	5	10
5. Shortness of breath on effort or at rest	0	2	5	7
6. Chest pain on breathing or coughing	0	2	5	10
7. Gets chest infections easily	0	2	5	10
8. Coughing up mucus/phlegm	0	2	5	10
9. Takes asthma medication	**No**		**Yes**	(10)

6. Total .....

Section 7.				
1. Burping up gas	0	2	5	10
2. Bloating after meals	0	2	5	10
3. Abdominal distention, swelling	0	1	3	5
4. Less than 1 bowel movement per day	0	1	2	3
5. Food intolerances, allergies	0	1	2	3
6. Foul smelling breath	0	1	3	5
7. Low vitamin B12 levels	**No**		**Yes**	(10)
8. Acne or Acne Rosacea	0	2	5	8
9. Eczema	0	1	3	5
10. Flaking, peeling or brittle nails	0	1	3	5

7. Total .....

Section 8.				
1. Past duodenal ulcers, stomach problems	**No**		**Yes**	(8)
2. Do you have an ulcer now ?	**No**		**Yes**	(10)
3. Do you use antacids ?	**No**		**Yes**	(8)
4. Stomach pains on lying down or bending after a meal	0	1	3	5
5. Stomach symptoms, heartburn, pain	0	2	5	8
6. Food, drink makes stomach feel better	0	2	5	8
7. Black stools (blood)	0	2	5	10
8. Helicobacter breath test positive	**No**		**Yes**	(10)

8. Total .....

Section 9.				
1. Abdominal cramps after eating meals	0	1	2	3
2. Abdominal cramps opening bowels	0	1	2	3
3. Loose stools, constipation	0	2	5	10
4. Tiredness after meals	0	1	3	5
5. Smelly stools	0	2	5	7
6. Acne, Food allergies	0	2	5	7
7. Inflammation of the small bowel	0	2	5	7
8. Mucous in stools	0	2	5	7
9. Fullness, indigestion for 2-4 hrs after meals	0	1	3	5
10. Bowel gas, flatulence, wind	0	1	3	5

9. Total .....

Section 10.				
1. Chronic fungal infections, thrush, parasites abnormal bacteria	0	1	3	5
Section 10 cont...	**A**	**B**	**C**	**D**
2. Low fibre diet	0	1	3	5
3. Constipation, diarrhoea, colitis	0	2	5	10
4. Antibiotic use (note frequency)	0	2	5	10
5. High meat intake	0	1	3	5
6. Abdominal bloating / distention	0	2	5	7
7. Bowel gas, flatulence, wind	0	2	5	7
8. Abdominal pain, Diverticulitis	0	1	3	5
9. Changeable bowel habits	0	2	5	7
10. Red blood in stool (or blood found in stool on testing)	0	2	5	10

10. Total .....

Section 11.				
1. Indigestion, pain or nausea after eating or nausea after drinking alcohol	0	2	5	10
2. Previous hepatitis or abnormal liver function tests	**No**		**Yes**	(10)
3. Pain under front right side of rib cage, right side of back	0	2	5	8
4. Yellowness of sclera (whites of eyes)	0	2	5	10
5. Indigestion or pains after fatty food	0	1	3	5
6. Light coloured stools, dark urine	0	1	3	5
7. High cholesterol or triglycerides	0	1	3	5
8. Gallstones, pain under right hand side of rib cage	0	1	2	3
9. Fatigue, tired all the time	0	1	2	3
10. Irritability, depression, foggy thinking	0	1	2	3
11. Reddened palms or skin	0	1	3	5
12. Generally feels unwell	0	1	3	5

11. Total .....

Section 12.				
1. Poor sense of smell and taste	0	1	2	3
2. Dark under the eyes, on cheeks	0	1	2	3
3. Catch colds and flu easily	**No**		**Yes**	(10)
4. Nasal blockage, mucus, post nasal drip, sore throat	0	2	5	7
5. Frequent antibiotic use	0	2	5	7
6. Cold sores, herpes, HPV, HIV	**No**		**Yes**	(10)
7. Ear, nose, throat, eyes, lung, skin infections	0	2	5	10
8. Discharge from ears	0	2	5	10
9. Slow healing wounds	0	2	5	10
10. Swelling in groin, armpits, neck	0	2	5	10

12. Total .....

Section 13.				
1. Hayfever, sinusitis	0	2	5	10
2. Eczema, psoriasis, dermatitis	**No**		**Yes**	(10)
3. Urticaria (hives)	**No**		**Yes**	(10)
4. Arthritis (osteo, rheumatoid)	0	1	3	5
5. Headaches & Migraine	0	2	5	10
6. Itching or red eyes	0	2	5	10
7. Mouth ulcers	0	2	5	10

Section 13. cont ..	A	B	C	D
8. Hyperactive, ADD, ADHD, Learning difficulties	**No**		**Yes**	(10)
9. Asthma, wheezing	**No**		**Yes**	(10)
10. Chronic cough/hoarseness	0	1	3	5
11. MS, SLE, other autoimmune diseases	**No**		**Yes**	(10)

13. Total .....

Section 14.

1. Fatigue, tired all the time	0	2	5	7
2. Poor tolerance to stress	0	2	5	10
3. Salt cravings	0	2	5	7
4. Poor exercise tolerance	0	2	5	7
5. Food sensitivities	0	1	3	5
6. Environmental pollutant sensitivity	0	1	3	5
7. Feels dizzy, blurry vision when rising or standing up	0	1	2	3
8. Irritability, rapid mood swings	0	1	2	3
9. Slow recovery from infections	0	1	2	3
10. Changes in skin pigmentation, colour	0	1	2	3

14. Total .....

Section 15.

1. Sensitive to cold	0	2	5	10
2. Irregular menstruation	0	1	3	5
3. History of infertility	0	2	5	7
4. Depression	0	1	3	5
5. Fatigue	0	1	3	5
6. Constipation	0	1	3	5
7. Dry skin	0	1	2	3
8. Fluid retention	0	1	3	5
9. Loss of hair anywhere on the body	0	2	5	10
10. Difficulty in losing weight	0	1	3	5

15. Total .....

Section 16.

1. Sweating if food is delayed, irritability if meals are missed	0	2	5	10
2. Frequent copious urination and increased thirst	0	1	3	6
3. Tremors or shakiness if meals missed	0	2	5	9
4. Dizziness after sugary food or drink	0	1	3	5
5. Craving coffee or stimulants	0	1	2	3
6. Headaches if meals are missed	0	2	5	10
7. Poor memory	0	1	2	3
8. Eating relieves symptoms	0	2	5	10
9. Difficulty in losing weight or slow recovery from infections	0	2	5	8
10. Immediate family member has a history of diabetes	**No**		**Yes**	(10)

16. Total .....

Section 17.

Section 17. cont ...	A	B	C	D
1. Bed wetting	0	2	5	10
2. Frequent urination	0	2	5	10
3. Frequent infections	0	2	5	10
4. Blood or protein in urine	0	2	5	10
5. Puffy eyelids	0	1	3	5
6. Antibiotics for urinary infections	0	2	5	10
7. Polyps in urethra or bladder	0	2	5	10
8. Strong smelling urine	0	2	5	10
9. Dripping after or poor urine stream	0	1	3	5
10. Incontinence on exertion, sneezing etc.	0	2	5	10

17. Total .....

Section 18.

*Symptoms that occur **before** periods*

1. Gains weight before and with periods	0	2	5	10
2. Bloating before periods	0	2	5	10
3. Irritability before periods	0	2	5	10
4. Anxiety	0	1	3	5
5. Depression	0	1	3	5
6. Skin eruptions	0	1	3	5
7. Craving carbohydrates, sugar, bread	0	1	3	5
8. Leg pains, heaviness, cramping	0	2	5	10
9. Headaches	0	2	5	10
10. Breast tenderness	0	2	5	10

18. Total .....

Section 19.

1. Irregular, delayed periods	0	2	5	10
4. Miscarriages	**No**		**Yes**	(10)
5. Pregnancy complications	0	2	5	10
6. Ectopic pregnancies	**No**		**Yes**	(10)
7. Vaginal infections	0	2	5	7
8. Known sexually transmitted disease	**No**		**Yes**	(10)
9. Primary infertility (has not had a child)	**No**		**Yes**	(10)
10. Secondary infertility (has had at least one child)	**No**		**Yes**	(10)
11. Polycystic ovary syndrome	**No**		**Yes**	(10)
12. Endometriosis	**No**		**Yes**	(10)

19. Total .....

Section 20.

*Symptoms that occur **during** periods*

1. Abdominal pain or cramping	0	2	5	10
2. Light or heavy blood flow/clots	0	2	5	10
3. Diarrhoea, constipation with periods	0	1	3	5
4. Pain or ache in low back or legs	0	2	5	10
5. Nausea with periods	0	2	5	10
6. Fatigue with periods	0	1	3	5
7. Headaches, migraines with periods	0	2	5	10

20. Total .....

Section 21.	**A**	**B**	**C**	**D**
1. Breast lumps	0	2	5	10
2. Breast tenderness	0	1	3	5
3. Ovarian cysts, Fibroids	**No**		**Yes**	(10)
4. Endometriosis	**No**		**Yes**	(10)
5. Family history of cysts / cancer	**No**		**Yes**	(10)
6. Abnormal pap smears	**No**		**Yes**	(10)
7. Cervical erosions	**No**		**Yes**	(10)
8. Mid-cycle pain	0	1	3	5
9. Hormonal birth control	**No**		**Yes**	(10)

21. Total .....

Section 22.				
1. Insomnia	0	1	3	5
2. Joint pain	0	1	3	5
3. Fatigue	0	1	3	5
4. Low libido	0	1	3	5
5. Mood changes	0	1	3	5
6. Menstrual irregularity	0	2	5	7
7. Hair loss	0	2	5	7
8. Menorrhagia (heavy periods)	0	2	5	7
9. Dry vagina	0	2	5	7
10. Night sweats, Hot flushing	0	2	5	10

22. Total .....

Section 24.				
1. Light headedness/vertigo	0	2	5	7
2. Walking difficulties	0	2	5	7
3. Poor bowel / bladder control	0	2	5	7
4. Speech difficulties	0	2	5	7
5. Weakness of limbs	0	2	5	7
6. Paralysis, spasticity	**No**		**Yes**	(10)
7. Poor co-ordination / balance	0	2	5	7
8. Muscle twitching	0	2	5	7
9. Sensory, perception changes - temperature, numbness, tingling	0	2	5	10
10. Short / long-term memory loss	0	2	5	10

24. Total .....

Section 25.	**A**	**B**	**C**	**D**
1. Cerebravascular - Stroke, transient ischaemic attacks, haemorrhage	**No**		**Yes**	(15)
2. Alzheimer's disease senile dementia	**No**		**Yes**	(15)
3. Tremor	0	2	5	10
4. Parkinson's disease	**No**		**Yes**	(15)
5. M otor neurone disease	**No**		**Yes**	(15)
6. Epilepsy	**No**		**Yes**	(15)

25. Total .....

Section 26.				
1. Chronic pain at any site	0	2	5	10
2. Headaches, migraines, cluster headaches	0	2	5	10
3. Neuralgia - Trigeminal following herpes/shingles infection	0	2	5	10
4. Addiction to recreational drugs	**No**		**Yes**	(15)
5. Difficulty giving up smoking	**No**		**Yes**	(15)
6. Need to have at least one alcoholic drink each day	**No**		**Yes**	(15)
7. Reflex sympathetic dystrophy	**No**		**Yes**	(15)
8. Chronic arthritis	0	2	5	10
9. Food addiction/ anorexia/ bulimia	**No**		**Yes**	(15)
10. Depends on medication for pain	**No**		**Yes**	(15)

26. Total .....

Section 27.				
1. Forgetful	0	2	5	10
2. Difficult concentration	0	2	5	10
3. Treated for schizophrenia	**No**		**Yes**	(15)
4. Depression	**No**		**Yes**	(15)
5. Obsessive compulsive disorder	**No**		**Yes**	(15)
6. Easily distracted, learning problems	0	2	5	10
7. Suicidal thoughts	**No**		**Yes**	(15)
8. Anxiety, Waking with anxiety	**No**		**Yes**	(15)
9. Panic Attacks	**No**		**Yes**	(15)
10. Mood swings	0	2	5	10

27. Total .....

Section 28.				
1. Vivid dreams	0	1	3	5
2. Light sleep	0	1	3	5
3. Sleep talking	0	1	3	5
4. Sleep walking	0	1	3	5
5. Snoring (sleep apnoea)	0	1	3	5
6. Difficulty falling asleep	0	1	3	5
7. Early morning waking	0	1	3	5
8. Frequent waking	0	1	3	5
9. Wake during night with difficulty getting back to sleep	**No**		**Yes**	(5)
10. Waking up exhausted	0	1	3	5

28. Total .....